Transitions
Health Care

2006 OCT 13 PM 2:47

Edwin C. Hirsch
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October 12, 2006

Linda Cole
Chief – Long Term Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215-2254

RE: Comments on COMAR 10.24.08 – Hospice Services

Dear Ms. Cole:

We have provided comments on COMAR 10.24.08, reserving, however, our right to provide additional comments before the end of the public comment period on October 26th. While these comments are directed primarily at hospice services, we also believe there may be a need for additional nursing home beds to accommodate increases in hospice inpatient care.

A stated mission of the Health Care Commission is to create a blueprint that assures that the State's health care system provides access, choice and quality. The proposed Plan vastly underestimates the need for hospice services in 2010 and compromises the chances that all residents in Maryland will have sufficient provider choices and readily available access to hospice care. The following is a summary of our comments on the Plan that are discussed in more detail below:

1) Base period estimates are understated;

2) Annual growth rates are too low;

3) Geographic footprint and redundancy are not sufficient; and

4) The Plan will not reestablish Maryland as a leader and innovator in hospice care.

1) Understated Base Year Estimates. Projecting the system's future needs starts with an accurate assessment of current needs. Currently, the forecast is based entirely on data from the hospice survey report and does not take into account thousands of other Maryland residents who die each year from causes where hospice is an appropriate end-of-life care option. In a letter sent last May, we urged the Commission to adopt a forecast methodology that independently assessed the current need for hospice services. In this letter we provided a suggested methodology that estimated need based on the cause death. In Table A, below, there is a ranking of causes of death in Maryland in 2002. This table shows that more than 69% of all deaths were attributable to cancers, heart disease and Alzheimer's, all of which are highly appropriate for hospice care. This table also shows that only 4% of all deaths were from unintentional injury, such a car accident, and that the remaining 27% of deaths were from other causes where, in many situations, patients would be eligible and appropriate for hospice care.

TABLE A

CAUSES OF DEATH IN MARYLAND

Rank	Causes of Death	% of Total
1	Heart Disease	35.7%
2	Malignant Neoplasms	30.9%
3	Cerebrovascular	8.4%
4	Chronic Low. Respiratory Disease	5.8%
5	Diabetes Mellitus	4.5%
6	Unintentional Injury	4.0%
7	Influenza & Pneumonia	3.3%
8	Septicemia	3.0%
9	Alzheimer's Disease	2.6%
10	Nephritis	1.9%
	Total	100.0%

In Table B, below, we then compared the hospice deaths in four urban counties included in the 2004 survey against three independent estimates of need based on causes of death. These independent estimates assumed that between 60 – 70% of all terminally ill patients were appropriate for hospice services. This comparison suggests that there is large unmet need for hospice services that are not included in the base year of the projections.

TABLE B

HOSPICE SURVEY DEATHS
VERSUS
ESTIMATES BASED ON THE CAUSE OF DEATH

	Survey (1)	Terminal Conditions where Hospice is an Appropriate Care Option(1)		
	Deaths	@ 60%	@ 65%	@ 70%
Anne Arundel	1,031	2,468	2,673	2,879
Prince George's	946	4,039	4,376	4,712
Baltimore	2,054	3,802	4,118	4,435
Montgomery	1,937	4,402	4,768	5,135

(1) Reported to have received hospice care. (2) Based on a percent of all deaths.

2) Low Growth Rate Assumption. The Centers for Medicare and Medicaid Services estimates that in FY 2006, Medicare/Medicaid would spend $7.1 billion for hospice services. This is an 87% increase from FY 2004 expenditure levels. Private sector estimates are that the hospice market basket will continue to grow at a double digit pace for the next 5 – 10 years. The growth assumptions used in the Plan's projections are approximately 6% and should be upwardly adjusted.

3) Current Geographic Footprint Does Not Provide Sufficient Access and Choice. The Plan does not address a need to license additional providers in those counties where there is only one licensed program. The Plan also does not address the more subtle need of expanding the geographic footprint and creating program redundancies to provide real choice. In health care systems where there is not a certificate of need requirement, geographic expansion and choice is largely driven by market need and competition. In Maryland, and other CON states, creating choice must be part of a comprehensive plan. It is our opinion that the Plan needs to be modified to assure that a sufficiently wide geographic footprint is created and that there are a number of active programs in each major market.

4) Maryland is No Longer a Leader in Hospice Care. In recent years the growth of hospice care services in Maryland has lagged behind many other states. This observation was recently voiced by the Commission's Executive Director who asked a group of hospice providers last February why Maryland's position as an early industry leader had slipped. Maryland's aging

population and families of terminally-ill patients deserve a health care system that is a leader and innovator in hospice care.

5) Competition Will Not Diminish Quality. The third part of the Commission's mission is quality. It has been suggested by some that the licensing of new hospice providers, especially the for-profit industry leaders, would have an adverse impact on the quality of care because it would require the current programs to divert financial resources for marketing initiatives and branding. Others have proffered that there are not enough trained staff to go around, especially RNs, and new programs would drain scarce talent. Still others have suggested that any competition for charitable donations would create financial hardships. These arguments are not grounded in any reality and additional competition will not result in any financial crisis, or any crisis of quality.

If you have any questions about these comments or wish to discuss these comments in greater detail, I will be pleased to make the time to visit you at your office.

Sincerely,

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Chairman

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